		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042028

Facility Name: Alden North Shore Rehab & HCC

Address: 5050 West Touhy (Number) Skokie (City) 60077 (Zip Code)

County: Cook

Telephone Number: (847)679-6100 **Fax #** (847) 679-3822

IDPA ID Number: 36-3978207

Date of Initial License for Current Owners: 08/06/99

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven M. Kroll

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	352	4,288	9,400	14,040	8
9	SNF/PED					9
10	ICF	734	4,049		4,783	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,086	8,337	9,400	18,823	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.45%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 8/14/99

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 8/14/66 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 72 and days of care provided 9,399

Medicare Intermediary AdminiStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	368,314	27,745		396,059	884	396,943		396,943			1
2	Food Purchase		192,843		192,843	(17,910)	174,933	2,333	177,266			2
3	Housekeeping	83,703	15,750		99,453	534	99,987		99,987			3
4	Laundry	31,534	12,554		44,088	333	44,421		44,421			4
5	Heat and Other Utilities			150,168	150,168		150,168		150,168			5
6	Maintenance	51,944		98,409	150,353	58	150,411	4,094	154,505			6
7	Other (specify):*											7
8	**TOTAL General Services**	535,495	248,892	248,577	1,032,964	(16,101)	1,016,863	6,427	1,023,290			8
	B. Health Care and Programs											
9	Medical Director			33,500	33,500		33,500		33,500			9
10	Nursing and Medical Records	1,319,738	108,665	2,232	1,430,635	5,007	1,435,642	(30,760)	1,404,882			10
10a	Therapy	14,642			14,642		14,642		14,642			10a
11	Activities	71,940	2,204	2,932	77,076		77,076		77,076			11
12	Social Services	39,439		1,046	40,485		40,485		40,485			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,445,759	110,869	39,710	1,596,338	5,007	1,601,345	(30,760)	1,570,585			16
	C. General Administration											
17	Administrative	133,947			133,947		133,947		133,947			17
18	Directors Fees											18
19	Professional Services			650,238	650,238		650,238	(628,882)	21,356			19
20	Dues, Fees, Subscriptions & Promotions			30,628	30,628		30,628	(21,050)	9,578			20
21	Clerical & General Office Expenses	249,708	20,514	27,599	297,821	200	298,021	40,266	338,287			21
22	Employee Benefits & Payroll Taxes			261,153	261,153	10,894	272,047	35,677	307,724			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,957	1,957		1,957	4,177	6,134			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			49,505	49,505		49,505	2,891	52,396			26
27	Other (specify):*			93,365	93,365		93,365	(93,365)				27
28	**TOTAL General Administration**	383,655	20,514	1,114,445	1,518,614	11,094	1,529,708	(660,286)	869,422			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,364,909	380,275	1,402,732	4,147,916		4,147,916	(684,619)	3,463,297			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden North Shore Rehab & HCC #0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			38,041	38,041		38,041	222,533	260,574			30
31	Amortization of Pre-Op. & Org.							6,018	6,018			31
32	Interest			285,531	285,531		285,531	464,761	750,292			32
33	Real Estate Taxes							152,178	152,178			33
34	Rent-Facility & Grounds			948,638	948,638		948,638	(948,424)	214			34
35	Rent-Equipment & Vehicles			10,240	10,240		10,240	7,933	18,173			35
36	Other (specify):*							41,575	41,575			36
37	**TOTAL Ownership**			1,282,450	1,282,450		1,282,450	(53,426)	1,229,024			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		382,006	1,057,488	1,439,494		1,439,494	(509,626)	929,868			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,918	50,918		50,918		50,918			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		382,006	1,108,406	1,490,412		1,490,412	(509,626)	980,786			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,364,909	762,281	3,793,588	6,920,778		6,920,778	(1,247,672)	5,673,106			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(55,774)	30		9
10	Interest and Other Investment Income	(116)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,400)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,981)	32		18
19	Entertainment				19
20	Contributions	(2,394)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(93,365)	27		24
25	Fund Raising, Advertising and Promotional	(16,274)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,403)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (176,707)	20	$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(460,167)	Pg 6's	34
35	Other- Attach Schedule	(610,798)	Pg 5a	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,070,965)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,247,672)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden North Shore Rehab & HCC

ID# **0042028**

Report Period Beginning: **01/01/2001**

Ending: **12/31/2001**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Skyline Valet backed out on page 5A	$ (48,290)	19	1
2	AMS allocation Marketing management fees	(120,635)	19	2
3	Workers Comp Insurance prior year exp adj on 5A	1,462	22	3
4	Real estate tax exp prior year adj backed out on 5A	(2,229)	33	4
5	Illinois healhtcare association pac fees backed out	(358)	20	5
6	insurance expense adjustment ($29 x # of beds in fac)	(2,697)	26	6
7	non-costs for hmo therapy c/a 5026	(20,293)	39	7
8	non-costs for hmo drugs c/a 5042	(14,070)	39	8
9	non-costs for hmo therapy c/a 5040	(253,715)	39	9
10	non-costs for hmo oxygen c/a 5080	(2,350)	39	10
11	back out chamber of commerce fees	(722)	20	11
12	back out non-allow. Interest on s/holder loans	(153,850)	32	12
13	back on non-costs in part b therapies (c/a's)	(1,018)	39	13
14	painting reclassed in 2000 (>$1,500)	725	6	14
15	adjust out 2000 over-deprec adj in 2001	7,243	30	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(610,798)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,400)	0	0	4,733	0	0	0	0	0	0	0	2,333	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	725	0	3,385	0	0	0	(16)	0	0	0	0	4,094	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,675)	0	3,385	4,733	0	0	(16)	0	0	0	0	6,427	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(29,609)	(1,151)	0	0	0	0	0	0	(30,760)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(29,609)	(1,151)	0	0	0	0	0	0	(30,760)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(168,925)	3,200	(463,157)	0	0	0	0	0	0	0	0	(628,882)	19
20	Fees, Subscriptions & Promotions	(21,151)	0	101	0	0	0	0	0	0	0	0	(21,050)	20
21	Clerical & General Office Expenses	0	523	9,797	20,332	9,614	0	0	0	0	0	0	40,266	21
22	Employee Benefits & Payroll Taxes	1,462	0	32,245	0	1,970	0	0	0	0	0	0	35,677	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,177	0	0	0	0	0	0	0	0	4,177	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,697)	5,588	0	0	0	0	0	0	0	0	0	2,891	26
27	Other (specify):*	(93,365)	0	0	0	0	0	0	0	0	0	0	(93,365)	27
28	**TOTAL General Administration**	(284,676)	9,311	(416,837)	20,332	11,584	0	0	0	0	0	0	(660,286)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(286,351)	9,311	(413,452)	(4,544)	10,433	0	(16)	0	0	0	0	(684,619)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Alden North Shore Rehab & HCC** **#** **0042028** **Report Period Beginning:** **01/01/2001** **Ending:** **12/31/2001**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(48,531)	256,798	11,855	0	2,411	0	0	0	0	0	0	222,533	30
31	Amortization of Pre-Op. & Org.	0	0	79	0	0	5,939	0	0	0	0	0	6,018	31
32	Interest	(158,947)	597,034	12,312	0	3,681	10,681	0	0	0	0	0	464,761	32
33	Real Estate Taxes	(2,229)	151,561	2,219	0	627	0	0	0	0	0	0	152,178	33
34	Rent-Facility & Grounds	0	(948,637)	213	0	0	0	0	0	0	0	0	(948,424)	34
35	Rent-Equipment & Vehicles	0	0	7,933	0	0	0	0	0	0	0	0	7,933	35
36	Other (specify):*	0	41,575	0	0	0	0	0	0	0	0	0	41,575	36
37	**TOTAL Ownership**	(209,707)	98,331	34,611	0	6,719	16,620	0	0	0	0	0	(53,426)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(291,446)	0	0	(35,808)	(73,779)	(108,593)	0	0	0	0	0	(509,626)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(291,446)	0	0	(35,808)	(73,779)	(108,593)	0	0	0	0	0	(509,626)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(787,505)	107,642	(378,841)	(40,352)	(56,627)	(91,973)	(16)	0	0	0	0	(1,247,672)	45

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 948,637	Northshore Associates Limited Partnership	100.00%	$	$ (948,637)	1
2	V	32	Interest Income	1,418	Northshore Associates Limited Partnership			(1,418)	2
3	V	32	Misc. income	500	Northshore Associates Limited Partnership			(500)	3
4	V	19	Audit fees		Northshore Associates Limited Partnership		3,200	3,200	4
5	V	21	Misc.		Northshore Associates Limited Partnership		523	523	5
6	V	33	Real estate taxes		Northshore Associates Limited Partnership		151,561	151,561	6
7	V	26	Insurance		Northshore Associates Limited Partnership		5,588	5,588	7
8	V	32	Interest - Mortgage		Northshore Associates Limited Partnership		598,952	598,952	8
9	V	36	Mortgage Insurance Prem.		Northshore Associates Limited Partnership		41,575	41,575	9
10	V	30	Depreciation		Northshore Associates Limited Partnership		256,798	256,798	10
11	V								11
12	V								12
13	V								13
14	Total			$ 950,555			$ 1,058,197	$ * 107,642	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits	$	Alden Management Services, Inc.	0.00%	$ 32,245	$ 32,245	15
16	V	19	Management fees	466,838	Alden Management Services, Inc.		3,681	(463,157)	16
17	V	21	Gen'l & Admin.		Alden Management Services, Inc.		9,797	9,797	17
18	V	6	maintenance/utilities		Alden Management Services, Inc.		3,385	3,385	18
19	V	24	autos/seminars		Alden Management Services, Inc.		4,177	4,177	19
20	V	20	dues/subscriptions		Alden Management Services, Inc.		101	101	20
21	V	30	depreciation		Alden Management Services, Inc.		11,855	11,855	21
22	V	31	amortization		Alden Management Services, Inc.		79	79	22
23	V	33	real estate tax		Alden Management Services, Inc.		2,219	2,219	23
24	V	34	rent		Alden Management Services, Inc.		213	213	24
25	V	35	rent-equipt/vehicles		Alden Management Services, Inc.		7,933	7,933	25
26	V	32	interest		Alden Management Services, Inc.		12,312	12,312	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 466,838			$ 87,997	$ * (378,841)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		2	TUBE FEEDING	$	PYRAMID HEALTH CARE SERVICES	100.00%	$ 4,733	$ 4,733	15
16	V		10	NURSING SUPPLIES	37,449	PYRAMID HEALTH CARE SERVICES		7,840	(29,609)	16
17	V		39	SUPPLIES / PERDIEM FEES	87,336	PYRAMID HEALTH CARE SERVICES		51,528	(35,808)	17
18	V		21	GENERAL & ADMIN.		PYRAMID HEALTH CARE SERVICES		20,332	20,332	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 124,785			$ 84,433	$ * (40,352)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		39	drugs	$ 229,817	Forum Extended Care II	100.00%	$ 180,078	$ (49,739)	15
16	V		10	house stock	5,318	Forum Extended Care II		4,167	(1,151)	16
17	V		39	iv	111,077	Forum Extended Care II		87,037	(24,040)	17
18	V		22	fringe benefits		Forum Extended Care II		1,970	1,970	18
19	V		21	gen'l & admin		Forum Extended Care II		9,614	9,614	19
20	V		32	interest		Forum Extended Care II		3,681	3,681	20
21	V		33	real estate taxes		Forum Extended Care II		627	627	21
22	V		30	depreciation		Forum Extended Care II		2,411	2,411	22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 346,212			$ 289,585	$ * (56,627)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		39	CPT REVENUES	$ 674,691	COMMUNITY PHYSICAL THERAPY	100.00%	$ 566,098	$ (108,593)	15
16	V		31	AMORTIZATOIN		COMMUNITY PHYSICAL THERAPY		5,939	5,939	16
17	V		32	INTEREST		COMMUNITY PHYSICAL THERAPY		10,681	10,681	17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 674,691			$ 582,718	$ * (91,973)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	maintenance expense	$ 2,621	Aldnen Bennett Construction	100.00%	$ 2,605	$ (16)	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 2,621			$ 2,605	$ * (16)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Floyd Schlossberg a.	President	Chief Executive	100.00	351,127	1.122	1.87	salary	$ 6697.4	21-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.00	78,611	0.748	1.87	salary	1499.42	21-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	71,814	0.748	1.87	salary	1369.78	21-1	3
4	Joan Carl d.	Secretary	Vice-President	0.00	177,602	1.122	1.87	salary	3387.58	21-1	4
5	see others attached on page 24			0.00	549,332	0.748	1.87	salary	10477.96	21-1	5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	$ 23,432		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8a…				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Prudential		x	mortgage	$62,000.00	3/1/98	$ 7,990,941	$ 8,299,753	2/28/27	7.2500	$ 598,952	1
2												2
3												3
4	Corp-line of credit		x								126,701	4
5												5
	Working Capital											
6	RELATED PARTY - CPT	X		OPERATIONS	NONE					VARIES	10,681	6
7	Related party - AMS/FECII	X		OPERATIONS	NONE					VARIES	15,993	7
8	Corp-line of credit											8
9	TOTAL Facility Related				$62,000.00		$ 7,990,941	$ 8,299,753			$ 752,327	9
	B. Non-Facility Related*											
10	interest income on Corp (Assoc.'s is taken out on pg 6)										(2,035)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,035)	14
15	TOTALS (line 9+line14)						$ 7,990,941	$ 8,299,753			$ 750,292	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	176,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	130,432	2
3. Under or (over) accrual (line 2 minus line 1).	$	(45,668)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	195,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	149,332	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1996	N/A	8
1997	N/A	9
1998	11,976	10
1999	67,899	11
2000	130,432	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden North Shore Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3746

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-28-429-017-0000	Nursing home facility	$ 3,861.71	$ 3,861.71
2.	10-28-429-018-0000	Nursing home facility	$ 12,528.48	$ 12,528.48
3.	10-28-429-019-0000	Nursing home facility	$ 12,534.57	$ 12,534.57
4.	10-28-429-020-0000	Nursing home facility	$ 12,448.87	$ 12,448.87
5.	10-28-429-021-0000	Nursing home facility	$ 12,448.87	$ 12,448.87
6.	10-28-429-022-0000	Nursing home facility	$ 12,438.32	$ 12,438.32
7.	10-28-429-023-0000	Nursing home facility	$ 12,427.42	$ 12,427.42
8.	10-28-429-024-0000	Nursing home facility	$ 12,418.44	$ 12,418.44
9.	10-28-429-025-0000	Nursing home facility	$ 12,418.44	$ 12,418.44
10.	10-28-429-026-0000	Nursing home facility	$ 12,418.44	$ 12,418.44
		TOTALS	$ 115,943.56	$ 115,943.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden North Shore Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-28-429-027-0000	Nursing home facility	$ 10,263.14	$ 10,263.14
2.	10-28-429-015-0000	Nursing home facility	$ 2,503.70	$ 2,503.70
3.	10-28-429-016-0000	Nursing home facility	$ 1,721.62	$ 1,721.62
4.			$	$
5.			$	$
6.		Related party -Alden Management	$ 118,551.00	$ 2,219.00
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 133,039.46	$ 16,707.46

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,208 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 40,437
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 8,107
4. Dates Incurred: 1999

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF	34,483	1997	$ 955,797	1
2					2
3	TOTALS	34,483		$ 955,797	3

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 18,359	$	22	$	$	$ 18,359	4
5											5
6	93		1999	1999	6,782,967	195,977	40	169,574	(26,403)	339,148	6
7											7
8											8
	Improvement Type**										
9	Related Party-Forum:										9
10	Leasehold Improvement-Remodeling			1980	19,335		20			19,335	10
11	Leasehold Improvement-Remodeling			1980	1,208		10			1,208	11
12	Leasehold Improvement-Remodeling			1986	645		5			645	12
13	Leasehold Improvement-Remodeling			1990	404		5			404	13
14	Leasehold Improvement-Remodeling			1991	94		5			94	14
15	Leasehold Improvement-Remodeling			1993	8,304	830	10	830		7,474	15
16	Leasehold Improvement-Remodeling			1993	6,504	671	9.7	671		6,035	16
17	Leasehold Improvement-sign			1994	261	22	12	22		174	17
18	Leasehold Improvement-dryvit			1995	443	44	10	44		310	18
19	Leasehold Improvement-new ac			1999	723	48	15	48		145	19
20	Leasehold Improvement-roof			1985	972	51	19	51		870	20
21	Leasehold Improvement-roof			1994	863	58	15	58		460	21
22	Leasehold Improvement-roof			1997	819	55	15	55		273	22
23	Leasehold Improvement-roof			1998	1,390	93	15	93		371	23
24	Leasehold Improvement-parking lot asphalt			2000	111	11	10	11		22	24
25	Leasehold Improvement-hallway lighting			2001	155	16	10	16		16	25
26	Leasehold Improvement-DAI			2001	195	19	10	19		19	26
27											27
28	Related Party-AMS:										28
29	Leasehold Improvement-Remodeling			1993	4,266		7			4,266	29
30	Leasehold Improvement-Remodeling			1994	2,112	64	7	64		2,112	30
31											31
32	Related Party-FECII:			1999	9,846	522	5	522		755	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	draper corp-electric screen	1999	$ 1,252	$ 125	10	$ 125	$	$ 292	37
38	dakota wiring & comm.-wiring for cable tv	1999	2,500	250	10	250		563	38
39	climate serv-repair compressor	1999	1,990	133	15	133		276	39
40	tci cable-install cable	1999	1,254	125	10	125		272	40
41	ABC-install tiles/repair	2000	4,011	267	15	267		490	41
42	ABC-mainten-various/construction	2000	5,000	500	10	500		917	42
43	ABC-mainten-various/construction	2000	10,000	1,000	10	1,000		1,750	43
44	ABC-mainten-various/construction	2000	10,000	1,000	10	1,000		1,667	44
45	new horizons-phone system	2000	5,744	574	10	574		1,005	45
46	new horizons-phone system & cable	2000	2,784	278	10	278		464	46
47	new horizons-phone system	2000	3,742	374	10	374		624	47
48	dbs contract.-lawn sprinkler system	2000	1,611	107	15	107		161	48
49	ABC-misc construction work	2000	5,347	1,069	5	1,069		1,248	49
50	ABC-misc construction work	2000	13,118	2,624	5	2,624		2,842	50
51	ABC-misc construction work (12/31/01 finished-begin exp '02)	2001	3,361		10				51
52	Laport (walk off mat carpet/floor covering)	2001	3,548	118	5	118		118	52
53	The Floor Source (PT carpet/floor covering)	2001	1,576	26	5	26		26	53
54	ABC-misc construction work	2001	289,721	19,315	15	19,315		19,315	54
55	New Horizon (phone system)	2001	1,256	21	10	21		21	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,227,790	$ 226,389		$ 199,986	$ (26,403)	$ 434,545	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 569,680	$ 74,758	$ 45,387	$ (29,371)		$ 21,620	71
72	Current Year Purchases	16,020	770	770			239	72
73	Fully Depreciated Assets	29,234	668	668			29,234	73
74								74
75	TOTALS	$ 614,934	$ 76,196	$ 46,825	$ (29,371)		$ 51,093	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	various	van/bus	1998-2000	$ 11,938	$ 3,797	$ 3,797	$	3	$ 6,200	76
77	various	bus	2001	49,826	9,965	9,965		5	9,965	77
78										78
79										79
80	TOTALS			$ 61,764	$ 13,762	$ 13,762	$		$ 16,165	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,860,285	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 316,348	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 260,574	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (55,774)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 501,803	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	n/a	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party: North Shore Assoc

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ Since this is			3
4	Additions				a related party,			4
5					this cost gets			5
6					backed out.			6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
Beginning 7/1/99
Ending 6/30/2009

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/02	$ 966,850
13.	12/31/03	$ 991,050
14.	12/31/04	$ 1,015,850

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 10,240 Description: copy machine lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

skilled nursing on-site

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 253,741	$		$ 253,741	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			47,600			47,600	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			373,350			373,350	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see pg 16a…	# of prescrpts				111,580		111,580	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see pg 16a…					143,598		143,598	13
14	TOTAL			$		$ 674,691	$ 255,178		$ 929,869	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden North Shore Rehab & HCC **#** 0042028 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 347,116	$ 353,288	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 59,216)	1,331,148	1,331,148	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,822	81,508	6
7	Other Prepaid Expenses	1,519	1,519	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): rent receivable/escrows		436,929	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,726,605	$ 2,204,392	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		955,797	13
14	Buildings, at Historical Cost		7,839,086	14
15	Leasehold Improvements, at Historical Cost	367,813	367,813	15
16	Equipment, at Historical Cost	119,140	1,031,447	16
17	Accumulated Depreciation (book methods)	(55,948)	(654,275)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 431,005	$ 9,539,868	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,157,610	$ 11,744,260	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 337,061	$ 337,415	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	620,000	620,000	29
30	Accrued Salaries Payable	158,490	158,490	30
31	Accrued Taxes Payable (excluding real estate taxes)	39,610	39,610	31
32	Accrued Real Estate Taxes(Sch.IX-B)		195,000	32
33	Accrued Interest Payable		49,799	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accrued expenses/due to State of Il	316,672	316,672	36
37	resident funds/credits	23,651	23,651	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,495,484	$ 1,740,637	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,299,753	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	due to affiliates	2,816,972	2,974,025	43
44	stockholder loans, plus accr'd inter.	1,876,064	1,876,064	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,693,036	$ 13,149,842	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,188,520	$ 14,890,479	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,030,910)	$ (3,146,219)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,157,610	$ 11,744,260	48

***(See instructions.)**

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,110,811)	1
2	Restatements (describe):		2
3	**External auditor's adjustments made after 2000 cost**		3
4	**report was submitted. These adj's have no effect on costs**		4
5	**(bad debt expense-non-allowable, and medicare revenue).**	(54,894)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,165,705)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(865,205)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (865,205)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,030,910)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,341,840	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,341,840	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	2,297	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,297	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	512	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	463,171	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 463,683	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	116	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 116	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	miscellaneous/various	920	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 920	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,808,856	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,150,102	31
32	Health Care	1,558,220	32
33	General Administration	1,154,759	33
	B. Capital Expense		
34	Ownership	1,282,450	34
	C. Ancillary Expense		
35	Special Cost Centers	1,477,612	35
36	Provider Participation Fee	50,918	36
	D. Other Expenses (specify):		
37	Note: will not tie due to related party in schedule V.		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,674,062	40
41	**Income before Income Taxes (line 30 minus line 40)****	(865,205)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (865,205)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	224	1,380	$ 41,294	$ 29.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,255	22,189	597,167	26.91	3
4	Licensed Practical Nurses	4,165	4,184	110,879	26.50	4
5	Nurse Aides & Orderlies	42,580	44,248	498,976	11.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	554	562	4,651	8.28	8
9	Activity Director	1,888	2,580	36,328	14.08	9
10	Activity Assistants	3,329	3,480	35,613	10.23	10
11	Social Service Workers	1,788	1,988	39,439	19.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,423	30,909	368,314	11.92	15
16	Dishwashers					16
17	Maintenance Workers	1,960	2,080	48,448	23.29	17
18	Housekeepers	9,300	9,877	83,703	8.47	18
19	Laundry	6,331	6,656	73,104	10.98	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,343	4,966	75,424	15.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	467	2,267	48,622	21.45	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Clinical support	2,315	571	9,991	17.50	32
33	Other(specify) Personnel	2,032	2,160	46,240	21.41	33
34	TOTAL (lines 1 - 33)	133,954	140,097	$ 2,118,193 *	$ 15.12	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	33,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,232	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	57	2,932	11-3	44
45	Social Service Consultant	20	1,046	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	77	$ 39,710		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	n/a	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
R Agpasa	administrator	0	$ 1,415
various executives	exec. Mngmnt	0	21,699
Agamso	administrator	0	72,518
Dalicandro(1264)Dipaolo(2572)	administrator	0	3,836
Glantz(428)/Palazzo(1395)	administrator	0	1,823
Perlmuter	administrator	0	31,409
Weber	administrator	0	1,247
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 133,947

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management Services	MNGT. FEES	$ 466,838
Blackman Kallick	ACCT. FEES	6,900
Marketing MNGR FEES -AMS	MNGT. FEES	
backed out on p. 5A		120,635
U.S. Gas	Utility consultant	837
Skyline valet backed out on 5A	Valet service backed out	43,800
Ken Fisch	Legal Fees	4,614
Jane Herman	Legal Fees	525
Achieve accreditation	JCHO consultant	5,786
Medi. Com	Software consultant	70
Misc. Prof Fees	Misc. Prof Fees	233
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 650,238

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	11,081
FICA Taxes	188,065
Employee Health Insurance	41,184
Employee Meals	17,910
Illinois Municipal Retirement Fund (IMRF)*	
Dental / Life insurance	2,504
Employee relations / emp vaccinations	11,006
Payroll misc. costs/tuition reimbursement	1,759
related party-ams	34,215
TOTAL (agree to Schedule V, line 22, col.8)	$ 307,724

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,920
Health Care Worker Background Check	1,008
(Indicate # of checks performed 144)	
Village of Skokie	535
Misc subsctiptions / fees	1,657
Illinois health association	4,357
related party-ams	101
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,578

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,450
Maryann G. Argamas	282
Seminar Expense	225
related party-ams	4,177
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,134

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	painting>$1500 for 2000	7/00	$ 2,176	3	$	$	$ 363	$ 725	$ 725	$ 363	$ 0	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,176		$	$	$ 363	$ 725	$ 725	$ 363	$	$	$

Facility Name & ID Number Alden North Shore Rehab & HCC **#** 0042028 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois healthcare assoc. $4357**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **PG. 5A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,826** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **NO** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **50,918**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **17,910** Has any meal income been offset against related costs? **NONE** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Friduss, Lukee, & Schiff, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Num Alden North Shore Rehab & HCC # 0042028 Report Period Begin. 01/01/2001 Endi 12/31/2001

XX. GENERAL INFORMATION:

	1	2	3	4	5	6		7		8
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference
see others attached on page 24								salary		21-1
Summary…										
Ami Pissetzki	finance relations	invest/bank			201,528.61	1.122	1.87	salary	3843.96	21-1
Bob Molitor	Vp of Operations	operations			192,401.88	0.748	1.87	salary	3669.87	21-1
Mary Chelotti Smith	In-house counsel	legal advis.			155,401.45	0.748	1.87	salary	2964.13	21-1